Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 23 July 2015

Subject: Collective Provider Response to the Commissioners' 2020 One Team Place Based Care 2020 Design Specification by the Manchester Provider Group

Report of: Manchester Provider Group

Summary

This report follows on from the One Team Commissioning Document, presented to the Committee in June and is the response of the Manchester Provider Group. The recommendations in the report were agreed by the Manchester Health and Well Being Board on 8 July 2015.

Recommendations

The Committee is asked to note the report.

Wards Affected: All

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Background documents (available for public inspection): None

Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 8 July 2015

Subject: Collective Provider Response to the Commissioners' 2020 One Team Place Based Care 2020 Design Specification by the Manchester Provider Group

Report of: Gill Heaton and Geoff Little on behalf of the Manchester Provider Group

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Summary:

In response to the Commissioners' 2020 One Team Place Based Care 2020 Design Specification, 11 health and social care providers in Manchester have written a collective response. It covers principles by which we will work together, a road map for integrated delivery and recommendations to enable us to implement change at scale at pace**.**

Recommendations:

The Board is asked to:

1. Acknowledge the collective direction and commitment of the 11 providers responding to the Commissioners' 2020 Design Specification and the principles by which we will work to deliver change, as set out in sections 3 and 4.

2. Agree the MPG roadmap as an overview of the 5 year initial integration programme as set out in section 5 and the supporting narrative in appendices 1 and 2.

3. Agree to the establishment of the MPG as part of the integrated governance structure under the HWB executive, and the accountability of city wide leadership group work streams to the MPG for delivery of integrated services, as set out in section 6.

4. Agree to further work between the MPG and commissioner colleagues to agree and understand the commissioning commitment to the process, to enable the delivery at pace of the integration programme across the 11 providers.

5. Agree to an option appraisal of organisational form being undertaken by the end of 2015.

Board Priority(s) Addressed: Health and Wellbeing Strategy priority

Summary of contribution to the strategy

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	
Educating, informing and involving the community in improving their own health and wellbeing	
Moving more health provision into the community	The key aim of the response by MPG to the Commissioners' 2020 Design Specification is to design and deliver services to shift care to the community and the strengthening how teams work in a 12/3/1 model.
Providing the best treatment we can to people in the right place at the right time	
Turning round the lives of troubled families	
Improving people's mental health and wellbeing	Community based mental health services are an integral part of the MPG response to the Commissioners' 2020 Design Specification.
Bringing people into employment and leading productive lives	The integration of services needs to link delivery of health and social care to wider determinants of health such as employment, housing and education.
Enabling older people to keep well and live independently in their community	Closer multidisciplinary working between organisations in the MPG, and health and social care practitioners, will benefit people with multiple health and social care needs.

Lead Board Members:
Sir Mike Deegan, Gillian Fairfield, Michelle Moran, Attila Vegh

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

- Living Longer Living Better Strategy 2013
- Five Year Forward View - NHS England, October 2014
- Examining new options and opportunities for providers of NHS care – The Dalton Review – Department of Health, December 2014
- General practice and integration: Becoming architects of new care models in England – A paper for discussion – British Medical Association, April 2015
- Care Act 2014 - Department of Health, May 2014
- Greater Manchester Agreement: Devolution to the Greater Manchester Combined Authority and transition to a directly elected Mayor - *Memorandum of Understanding between Greater Manchester local authorities, Greater Manchester Clinical Commissioning Groups and NHS England,* February 2015

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Section 1 Introduction and Background

1.1 This document is a collective response by 11 NHS and social care statutory providers to the Living Longer Living Better 2020 One Team design specification (known throughout as Commissioners' 2020 Design Specification). This includes all GP organisations in the city, all acute and integrated community trusts in the city, the mental health trust, the council and the ambulance service.

1.2 This is the first time all 11 providers have come together to respond with one voice to a commissioning specification. In so doing we acknowledge that for the people of Manchester we are better working together than separately and that our direction of travel in the future is to build on what we have started as a group together.

1.3 We have agreed a set of principles by which we will work, which describe how we want to behave and deliver, as statutory organisations that are held together, by our wish to deliver together the best services for Manchester people.

1.4 We have developed a high level integration roadmap which will see us come together to deliver services in our communities based on the 12 hubs, three localities and 1 city model. This will include those services that are delivered by primary care, community, hospital, social and ambulance practitioners. In doing so we will work together for the people of Manchester, creating teams which can deliver care in the right place, at the right time, for and with the people that we serve.

1.5 We recommend that the Manchester Provider Group (MPG) be established as part of the governance structure of the city for integrating its organisations' services in the 12/3/1 model, so that it can provide the collective response and drive for service implementation that is needed to deliver the city's services at scale and pace.

Section 2: MPG Signature Page

2.1 The organisations outlined below make up the newly formed MPG. Those named have agreed in principle, on behalf of their organisations, to the direction and collective commitment in the document. A next step to taking the work forward will be to take the commitments through each organisation's governance structures.

2.2.1 The MPG is developing this work in response to Commissioners' 2020 Design Specification but also in the context of GM Devolution. We will continue to work to Manchester's health and social care reform programme's four strategic aims of improving health outcomes, improving services, financial sustainability and supporting self reliance. We recognise that there is work underway in the city to develop the Locality Plan as part of Manchester's response for GM devolution. We understand that we will need to work together on the

proposals within this document and their contribution to the financial stability of the health and social care system as set out in the Locality Plan.

HWB executive lead member for producing collective provider response – Central Provider Partnership Chair	Gill Heaton	Deputy Chief Executive / Chief Nurse - CMFT
Primary Care Manchester	Dr Vish Mehra	Chairman
North Primary Care Federation	Dr Sohail Mushi	Chairman
South Manchester GP Federation / Chair	Dr Simon Baxter	Chairman South Manchester Provider Partnership
Manchester Local Medical Committee	Dr Tracey Vell	Chief Executive
GTD (GP Out of Hours Provider)	David Beckett	Chief Executive
Manchester City Council	Geoff Little	Deputy Chief Executive
CMFT	Julia Bridgewater	Chief Operating Officer
PAHT	Hugh Mullen	Director of Operations
UHSM	Silas Nicholls	Chief Operating Officer / Deputy Chief Executive
MHSCT	John Harrop	Director of Strategy, Transformation and Performance
NWAS	Dr David Ratcliffe	Deputy Medical Director

Section 3: MPG Commitment to One Team 2020 Specification

3.1 The 11 providers are collectively responding to the Commissioners' 2020 Design Specification. As a group we believe that the strategic direction of Living Longer Living Better as outlined in the specification, to deliver integrated services for the population around a one team 12/3/1 model, is the direction we all want to take.

3.2 We believe that by doing this together we will achieve more than working separately. In so doing we will work towards a city which delivers integrated health and social care services for its population.

3.3 We will therefore act collectively as the MPG working together through this joint identity. Our group will strive to work with others who are vital to creating the 2020 model, such as the voluntary sector and wider primary care organisations, to achieve this aim.

3.4 By working in this way we will start to create a vehicle for change which will build connections and capacity, delivering services differently across the city, making sure that what works, works well for the people of Manchester and is as local as possible.

3.5 We therefore aspire to be an integrated health and social care city for Manchester's population which will:

- Help to achieve better health and well being outcomes for the Manchester population
- Promote independence and champion prevention
- Working with local communities in the places we deliver services
- Working more closely with carers, voluntary and community sector groups whilst recognising the valuable contribution to care that they make
- Delivering the most effective, responsive and efficient services that are integrated as close to a person's home as possible
- Work to achieve financial stability for our health and social care system
- Be clear as the MPG in our role in relation to others delivering integrated care in the Greater Manchester conurbation

3.6 We will work to integrate, where appropriate, a range of services over the next five years in the one team 12/3/1 model. However, in the first instance we believe these to be our local district general hospital services, our community health services, our social care services, our GP primary care services, our community mental health services, our public health services and our ambulance services. This is a wider scope than proposed in the Commissioners' Design Specification, but we feel it is valid if we are to deliver transformational change across all providers. We recognise that as we start to design and deliver services differently we will need, and want to, build on our work with the wider primary care and third sector providers.

3.7 We will work in the context of our national, regional and local strategic policies ensuring that we make the most of the opportunities that are arising, particularly from the Five Year Forward View, the changing role of commissioning for primary care. We will take the opportunities that Greater Manchester Devolution will bring to move at pace and scale.

3.8 As we start to design and deliver our services differently in a one team 12/3/1 model we will start to behave differently, putting people and place before our organisational self interest, ensuring we are building local services for local people. We will explore how as a group we may deliver services through a different entity. We will see a changed form as a way of transforming what we

do, by taking away some of the boundaries that prevent us from delivering more integrated services together: be this workforce, information technology or our estate.

Section 4: MPG Principles to Working Together to Achieve 2020

4.1 MPG aims to collectively work to, and hold each other to account to the working principles outlined below to deliver the 2020 principles:

- Act in the best interests of service users and the public
- Work as a partnership of equals
- At all times to act in good faith towards one another
- Act in a timely manner and respond accordingly to requests for support
- Communicate openly about concerns, issues or opportunities relating to the MPG
- Seek to develop as a collaborative in order to achieve the full potential of the MPG
- Adopt a positive outlook and to behave in a positive, proactive manner
- Focus on the care and experience of service users and potential beneficiaries of the collaborative services
- Assume joint responsibility for the achievement of agreed outcomes
- Share the risks and rewards associated with good or poor overall performance
- Promote innovation and co production
- Work together on an open book basis (including cost transparency)
- Manage appropriately and safely any information of a confidential nature (whether shared between the parties, or generated by the MPG)
- Perform its obligations under this Agreement (and any Service Level Agreement) in accordance with Good Industry Practice and all applicable Laws

4.2 MPG will work to integrate services over the next 5 years to the vison of the Commissioners' 2020 Design Specification, and using the principles as outlined above as a framework by which all 11 provides will work.

Section 5: MPG Direction and Timeline

5.1 MPG recognises the strategic direction at national, regional and local level that is looking at new provider models, the integration of health and social care and the reform of the public sector through the process of devolution. Over the next five year we hope to integrate across the city, localities and neighbourhoods in a 12/3/1 model to deliver the Commissioners' 2020 Design Specification.

5.2 The diagram below shows the overarching approach we will take. The timeline is a pictorial representation of how the 11 organisations wish to design and deliver services in a 12/3/1 one team approach, over the next five years. The circles in blue denote services being delivered in the future in a place based model in either 12 hubs, three localities or across the city.

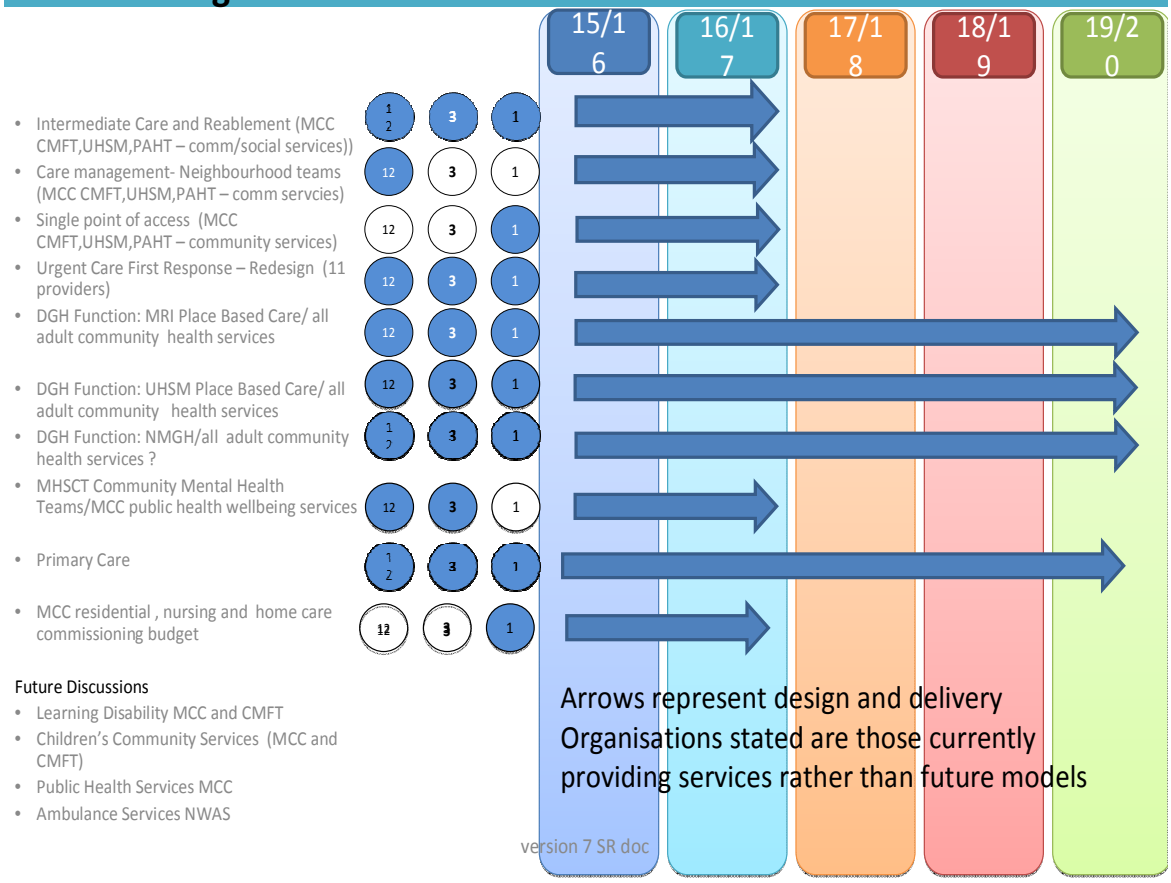
5.3 The first four lines of the table are based on current programmes of work in the city where there are already agreed commissioner intention to deliver services differently. These services are intermediate care and reablement, care management and neighbourhood tams, single point of access and urgent care first response. We have outlined the detail of all these areas in section 7 of this document.

5.4 The next three lines of the table describe the district general hospital and adult community health services delivered by PAHT, UHSM and CMFT. It should be noted that there are a wide range of services across the city and would include urgent care, in patient and out patient services in areas such as general surgery, general medicine, specialist medicine, diagnostics, medicine management and therapy. It also includes approximately 50 adult community health services across the three trusts which are delivered in the 12 hubs, three localities and across the city. These are outlined in more detail in section 6 of this document.

5.5 The next three lines in the table relate to MHSCT, MCC and primary care, with each organisation giving an overview of how this could be delivered in a 12/3/1 integrated model described in section 6 of this document.

5.6 In summary each organisation, in section 6 and 7 , explains the high level plans, in relation to the pictorial timeline, as to how they envisage their organisations will move towards a more integrated approach in terms of one team and place based working with partners in the MPG. It must also be stated that the MPG would want to work with partners in other sectors, as we believe this is only the start of a different approach to how we deliver services in the city, and the role of carers, the voluntary sector, housing and the other primary care providers such as pharmacy, optometry and dentistry are vital parts of how we create a place based model.

Manchester Provider Group 2020 One Team Place Based Care: Integration Timeline – Health and Social Care Function



Section 6: Making It Happen

6.1 Proposed Memorandum of Understanding and Exploration of Organisational Form

6.1.1 The MPG will build upon the principles in Section 4 in how we work together to deliver change. It is recognised that there is a need for a more formal basis for the collaborative working between the organisations. In the first instance, a Memorandum of Understanding (MOU) will be considered between the parties, to govern the relationships and behaviours while the preparatory work is being undertaken. The MOU will help to define:

- The partnership principles (i.e. partnering behaviours)
- The nature of the programme, including the purpose and scope of the integration work
- The options for future organisational forms, and a mechanism for determining the most appropriate form.
- The planned delivery timescale for implementation of the project including the agreement of integration proposals and the future organisational form by December 2015.

6.1.2 The MOU also envisages the future agreement of a more substantial Strategic Partnering Agreement. This would be the document that would govern any new organisational form if agreed, and the partnership working between the parent organisations, from the point of implementation of service integration.

6.1.3 Amongst other functions, the Strategic Partnering Agreement would make provisions for the establishment of appropriate multi agency governance arrangements, and this would be likely to include a Strategic Partnership Board.

6.1.4 For present purposes, it is assumed that these governance arrangements would involve all of the participating provider organisations, but would not include commissioner organisations – i.e. the focus of these arrangements would be on the operational management of the relevant services within Manchester. It is recognised that these new governance arrangements are likely to require some ceding of authority from the parent organisations, but at the same time there must be a balance that continues to allow the parent organisations to have effective oversight of the provision of services.

6.1.5 For present purposes, the provider partnership vehicle will continue to utilise the title of “Manchester Provider Group”, though there would be the option of adopting an alternative title when the Strategic Partnership Agreement is put in place. The relationship with commissioners would be through a contractual mechanism, though this might have significant risk sharing arrangements. Depending on whether a different organisational form is chosen, the formal contractual relationship could be with the partnership, or with the parent organisations.

6.1.6 In this scenario, MPG would draw its authority directly from the Boards of the provider organisations (through the provisions of the Strategic Partnership Agreement, rather than through the Health and Wellbeing Board. An approach of this sort might also require some restructuring of the governance arrangements that sit under HWB.

6.2 Finance

6.2.1 MPG will work with health and social care commissioners to deliver the LLLB Programme, which is a key component of the Manchester Locality Plan. As well as ensuring that patients and clients get the best and most appropriate care, LLLB will support Manchester's contribution to making the Greater Manchester health and social care system financially sustainable by 2020/21.

6.2.2 The MPG will work with commissioners to assess the shifts in resources between settings and services that will accompany the development of integrated community services over the next five years.

6.2.3 At the same time, there will be an analysis of each phase of the LLLB Programme in order to establish:-

- a definition of patient/client cohorts affected, together with detail of how people meeting that definition will be identified
- an estimate of the numbers of the people within the cohort within the city over the next five years
- a systematic evaluation of the costs and benefits of the new service models, in comparison to the existing arrangements
- an overall assessment of the financial implications of these changes for the various partners organisations within MPG

6.2.4 The detailed design of individual phases of the programme will be adjusted in the light of the above analysis.

6.2.5 The MPG will work with commissioners to develop and implement a monitoring and evaluation process to track actual costs and financial benefits in real time. This will track the impact of investment in the LLLB work streams to reductions in activity levels, including where and when those reductions lead to savings in other parts of the system. This monitoring and evaluation process will be used to manage risk and ensure that the agreed shifts in resources are achieved over the five year period.

6.2.6 For the purpose of the financial analysis, Commissioners' Design Specification proposal for 50% of resources saved from secondary care to be invested in out of hospital care is accepted.

6.2.7 The MPG will develop proposals for additional investment (capital and revenue) in the first year or two of the five year programme to achieve financial sustainability at the end of the five years. The additional investment will fund increases in the speed of scaling up implementation of LLLB.

6.2.8 The financial analysis and evaluation of LLLB will be kept within the context of the wider financial analysis of the Locality Plan.

6.3 Partnership with Commissioning

6.3.1 The MPG welcomes the coming together of commissioners to produce the 2020 Design Specification. In order to deliver a changed provider model for the future we will need to work with our commissioner colleagues. For the MPG this means at least 6 different organisations/teams: the three Manchester CCGs, the specialist services commissioning team, the council, NHS England and Blackpool CCG who commission NWAS on behalf of the North West CCGs.

6.3.2 We recognise that there are different commissioning approaches which will need to be understood and married if we are to deliver a coherent delivery model. It must also be stated that in the case of NWAS, Blackpool CCG has not been part of the Commissioners' 2020 Design Specification. We welcome the commissioners working to bring a coherent specification across all commissioning disciplines within and outside Manchester to enable this work to begin.

6.3.3 The MPG would also want to explore further with commissioners how we integrate mental and physical health and achieve greater coherence between the Commissioners' 2020 Design Specification and the current mental health commissioning intentions that are based on a pathways model, to ensure it is consistent with the one team approach which we are building in the 12/3/1 model.

6.3.4 The MPG would seek a commitment to a close working relationship with commissioner colleagues in order that that there is a clearly understood process between commissioners and the MPG on how the 2020 Design Specification will continue to be scoped and the ongoing detail of contractual and performance arrangements in order to deliver integrated services across the MPG and the 12/3/1 model for 2020.

6.4 Provider Collective Governance

6.4.1 For the purposes of this work we are not acting as a partnership but working as a group to respond to the specification but also to look at options on entity. We will relate to, and work with, our three provider partnerships but it is assumed that the work we will undertake is different from that undertaken by the three provider partnerships already established in the city. We believe that the provider partnerships are a vital and important part of the cultural and behavioural change of how all sectors work together at a service level. The provider partnerships include many more providers than those who are the statutory sector represented by the MPG, as they have the third sector and carers as vital and leading components who will be the change agents for enabling services to integrate at pace in the 3 localities and the 12 hubs.

6.4.2 It must also be recognised that as 11 providers we have a variety of different statutory forms. In particular it should be stated that MHSCT's future as an independent entity is unclear. It is important to note that the Trust is engaged in a Trust Development Authority led process that will determine its future. This process will run in parallel to the Commissioners' 2020 Design Specification. It is critical that the views of MPG about the role and priorities for mental health services should be expressed so that we can continue to influence the future direction of the services in the city.

6.4.3 The MPG is proposing that as a collective of the 11 providers that we continue to meet and to be formally constituted as accountable to the HWB Executive working towards the arrangement as set out at the beginning of section 8. The MPG's role will be to deliver the integrated 12/3/1 road map across the 11 providers. In so doing we will call on the capacity and work of the city wide leadership group, in particular for the enabling work streams around design, estates, IT, workforce, communication and engagement, believing that there should be a direct accountable role to the MPG for the delivery of these work streams and therefore the 2020 model.

Section 7: Recommendations

7.1 The HWB executive is asked to:

7.2 Acknowledge the collective direction and commitment of the 11 providers responding to the Commissioners' 2020 Design Specification and the principles by which we will work to deliver change, as set out in sections 3 and 4.

7.3 Agree the MPG roadmap as an overview of the 5 year initial integration programme set out in section 5 and the supporting narrative in appendices 1 and 2.

7.4 Agree to the establishment of the MPG as part of the integrated governance structure under the HWB executive and the accountability of city wide leadership group work streams to the MPG for delivery of integrated services, as set out in section 6.

7.5 Agree to further work between the MPG and commissioner colleagues to agree and understand the commissioning commitment to the process to enable the delivery at pace of the integration programme across the 11 providers

7.6 Agree to an option appraisal of organisational from taking place before the end of 2015.

19th June 2015

MPG Organisation Narrative

This appendix outlines what the organisations, that make up the MPG, aim to do over the next five years to deliver the Commissioners' 2020 Design Specification. It is our belief that this will change services through each of the sectors working together to integrate and develop services in a 12/3/1 place based care model.

1. General Practice

1.1 Outlined below is the description of how General Practice will be involved in the integration of services in response to the Commissioners' 2020 Design Specification.

1.2 The 95 General Practices in Manchester have as their main asset their highly committed, skilled and professional 368 GPs not including locum and portfolio GPs. Together the practices serve a population of approximately 575,000 across Manchester and its surrounding boroughs, seeing a proportion of the 360 million consultations which take place nationally in General Practice each year.

1.3 General Practice recognises the need to change, with services currently unsustainable and the crisis amongst the workforce in terms of recruitment and retention growing ever more so on a daily basis. General practice recognises the structures that have been developed i.e. 12/3/1 and also the 95 practices. General Practice is committed to working together as part of a wider partnership of three, locality based, Manchester providers (Northern Health GPPO, Primary Care Manchester, and South Manchester GP Federation). The LMC is the statutory representative body for General Practice and offers support to all GPs.

1.4 We are committing to plans on behalf of our constituents and members as a Local Medical Committee (LMC). The LMC is the statutory representative body for General Practice and offers support to all GPs regardless of whether they are locum, salaried or training and is not restricted to those in partnerships.

1.5 General practice is committed to:

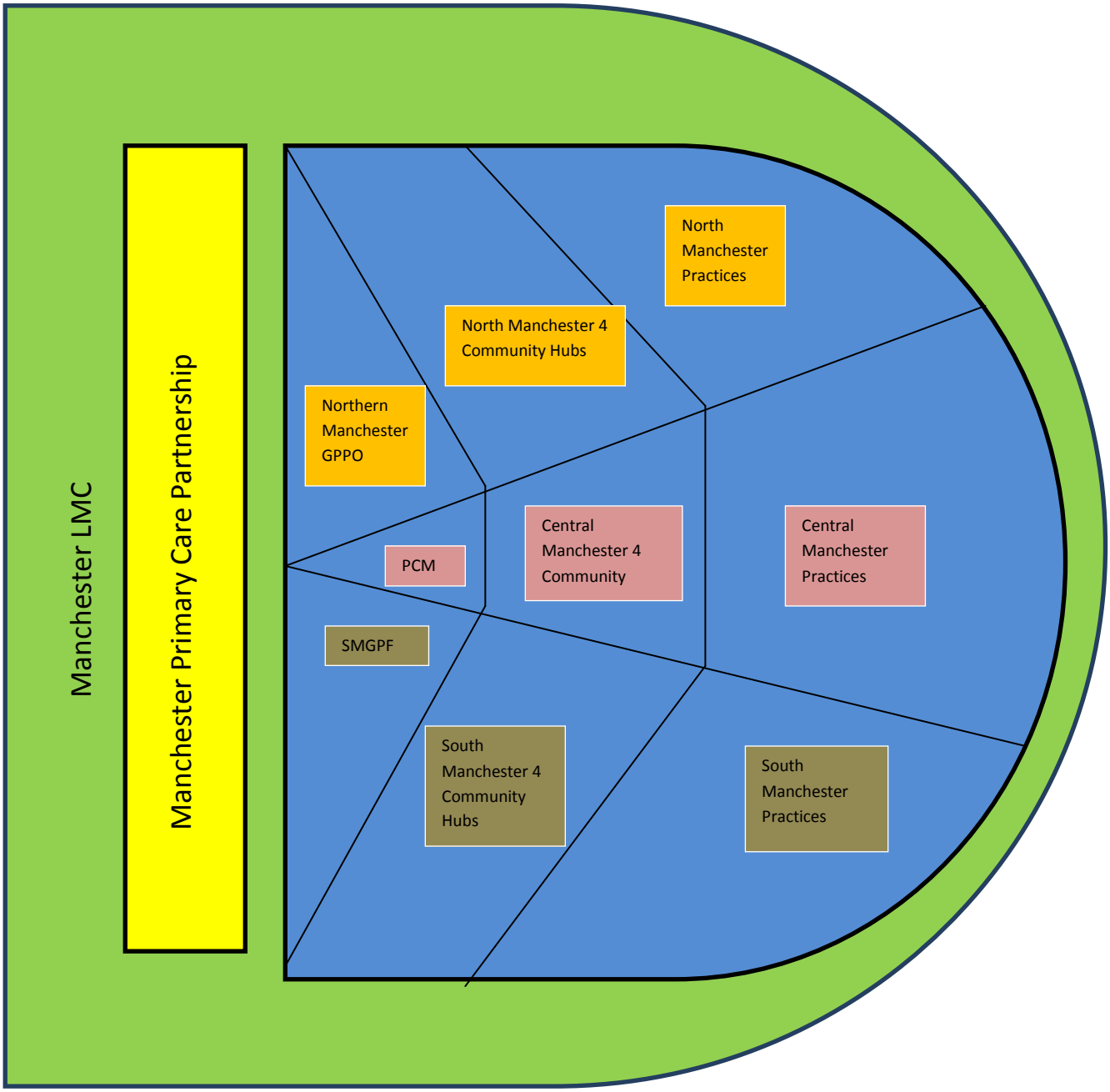
- Working collaboratively with the other NHS healthcare providers across Manchester to identify work that can be delivered differently on different models of scale;
- Identifying new roles for GPs exploring GP specialists status working across organisations that could lead to future options for the GP workforce;
- Integrating with offsite community services, Social Services, Mental Health, DGHs etc.
- Identifying new funding streams and different ways of commissioning and provision in particular with the new GP federations that have been developed;

- Looking at new models of healthcare that deliver long term sustainable benefits for patients, whilst providing stability for General Practice for the next 5 years;

- Looking at developing IT and estates solutions which are beneficial and useable by all without jeopardising patient confidentiality.

1.6 'Whilst General Practice will work collaboratively to integrate with community services, it is expected that the integrated teams will be based in hubs. It is not anticipated that the hubs will be based in GP Practice buildings. For further detail, please refer to the specific estates section'.

1.7 Currently General Practice is delivered in 95 practices across Manchester and the following diagram shows the relationship with all practices and the model of place based care that has been developed:



2. Four NHS Trusts - Pennine Acute Hospitals Trust, Central Manchester Foundation Trust, University Hospital of South Manchester, Manchester Mental Health and Social Care Trust

2.1 Introduction

2.1.1 Outlined below is the description of how the four NHS Trusts in the MPG will be involved in the integration of services in response to the Commissioners' 2020 Design Specification.

2.1.2 Our vision is to provide more integrated healthcare with our health and care partners, particularly in the community, and it is an area we are committed to as a key part of all our 5 year transformation programmes.

2.13 The four NHS Trusts in the MPG have as their main asset their highly committed, skilled and professional staff. Together they employ approximately 40,000 staff, who with their volunteers serve a population across Manchester and the North West.

2.1.4 However, as we come together as part of the MPG our vision is to work with other members to enhance the services we offer collectively to the Manchester population.

2.1.5 Manchester Trusts have amongst them the largest non teaching acute hospital Trust in the country (PAHT) as well as two nationally recognised teaching and tertiary Trusts (CMFT and UHSM), we also have one of the first integrated health and social care mental health trusts (MMHSCT). Together we are providing a wide range of clinical services and have national recognition for the quality of services we provide.

2.1.6 The population we serve is demographically diverse and faces some of the greatest challenges, including significant areas of deprivation, health inequality and chronic disease. Together, and with our partner provider organisations, it is our responsibility to develop and deliver high quality healthcare services around the needs of our patients, their families and the communities we serve.

2.1.7 For the purposes of the MPG and what will be in scope for redesign over the next five years we are highlighting the hospital and community services we run from North Manchester General Hospital (PAHT), Wythenshawe and Withington Hospitals (UHSM), Manchester Royal Infirmary (CMFT) and the adult community mental health services we provide across the city (MHSCT).

2.2 PAHT

2.2.1 North Manchester General Hospital site is one of four sites across PAHT's footprint delivering district general hospital services which are relevant for delivering the Commissioners' 2020 Design Specification. Services delivered from the site are commissioned and provided for the populations of North Manchester, Bury, Oldham and Heywood, Middleton and Rochdale. Approximately 60% of the site activity is commissioned and provided for the

North Manchester population. It is these functions that will be reviewed for alignment with 12/3/1 place based care delivery. This will be subject to and with consideration of the final decision relating to the Healthier Together review of health and social care.

2.2.2 Following a restructure of PAHT's clinical divisions all its community and integrated services are now within a newly created division of Integrated and Community Services. Also included within this division are the Trust's Allied Health Professional services. The belief is that this provides a strong platform for to build on our teams working in redesigned care management teams in the four neighbourhoods in North Manchester i.e.these services into the following 4 neighbourhood hub locality model in:

- Cheetham and Crumpsal
- Higher Blackely, Harpurhey, Charlestown
- Miles Platting, Newton Heath, City Centre, Moston
- Ancoats, Clayton, Bradford

2.2.3 The trust will build on its integration activity to date for 2020. It has already begun to develop teams working at neighbourhood (12) and North Manchester (3) 'place'. It will as part of design and implementation of the 2020 Design Specification review all services in scope for further alignment with 12/3/1 place based care delivery model.

2.3 CMFT

2.3.1 CMFT is one of the largest teaching and tertiary foundation trusts in the country comprising of 6 hospitals providing adult and children services to the population of Manchester, Greater Manchester and the North West. Manchester Royal Infirmary (MRI) is one of the six hospitals. It has four clinical divisions which provide local district hospital and community services to local people they are: Medicine and Community Services, Specialist Medical Services, Surgery and Clinical and Scientific Support. As part of its move to a 12/3/1 model MRI is working, through its place based care board, towards creating a platform for change, to integrate adult social care with community health services and establish an integrated system and way of working that meets the needs of Manchester people. This new way of working at MRI will also include the CMFT corporate functions of informatics, estates, workforce, organisational development and communications and engagement.

2.3.2 The MRI is essentially the local DGH function of CMFT and will, with corporate services create a community offer for the 2020 Design Specification. The objective is in the context of a 5 year plan to provide a local model for the Manchester population, providing a One Team approach for services in a 12/3/1 model. This will be at a city, locality and neighbourhood level in:

- Gorton and Levenshulme
- Rusholme, Moss Side and Hulme
- Ardwick and Longsight
- Chorlton, Fallowfield and Whalley Range.

2.4 UHSM

2.4.1 UHSM is a major acute teaching hospital trust providing services for adults and children at Wythenshawe Hospital and Withington Community Hospital, and Community Services for the local population.

2.4.2 UHSM's strategy aligns to place based approach to health and social care across Manchester. The South Manchester locality is organised in four patch based / neighbourhoods, namely:

- Wythenshawe
- Wythenshawe and Northenden
- Fallowfield and Withington
- Burnage, Chorlton and Didsbury

2.4.3 In South Manchester it is envisaged that community services and acute services being delivered out of GP Practice, Health Centres, Day / Out Patient facilities are included in the scope of work. The Strategy is to:

- To shift care from Acute to Out of Hospital
- To create networks of services to better support people as close to or at home
- To develop joined up pathways across health and social care, vertical and horizontal, resulting in a reduction in demand on health and social care services; key proxy for health is reduction in demand for primary care

2.4.4 UHSM's Community Services are currently being transitioned into an Integrated Community Services Directorate (ICSD). Within the ICSD, and supporting the integration agenda, are three South Manchester CCG community service specifications that are currently being implemented by UHSM: 1. Integrated Community Nursing Service; 2. Integrated Community Rehabilitation Service; 3. Integrated Community MSK, Rheumatology and Pain Service. These specifications provide the foundation to support the place based principles of One Team, the imminent integration of Adult Social Care and Community Health Services and the wider Living Longer Living Better (LLLB) integration agenda.

2.4.5 UHSM and CMFT have recently entered into a formal partnership arrangement of which the agenda for integration and the role of Withington Community Hospital will be amongst the priorities for joint working between the trusts.

2.5 Common Design Across PAHT, UHSM and CMFT

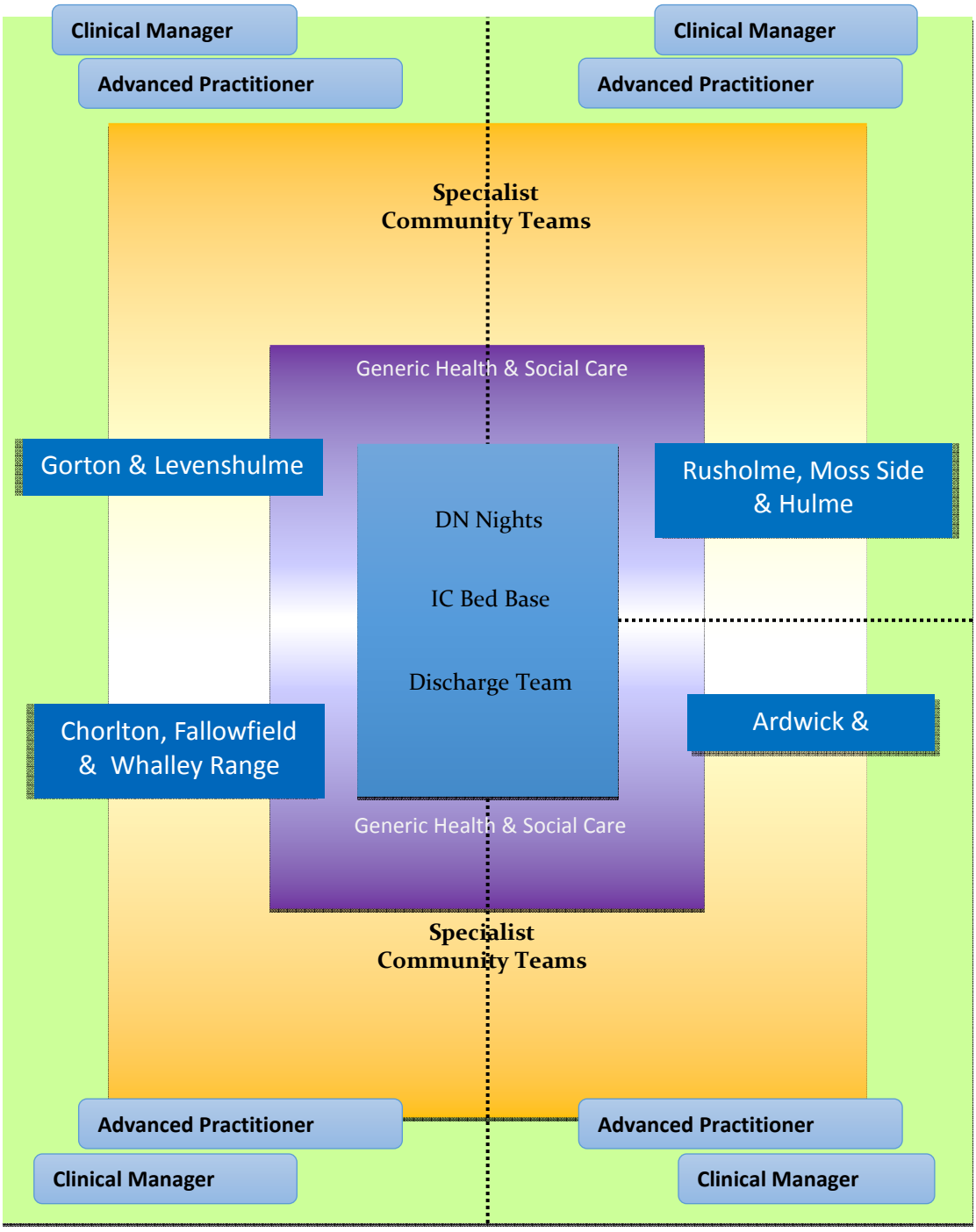
2.5.1 The focus for all the three acute and integrated community Trusts will be to develop services in the 12/3/1 model which will mean new models of care involving, amongst others, GPs, hospital services, social care and carers which will deliver locality based services. For example the focus initially in Central has been on developing these services into the following 4 hub locality model in

- Gorton and Levenshulme
- Rusholme, Moss Side and Hulme

- Ardwick and Longsight
- Chorlton, Fallowfield and Whalley Range

2.5.2 Each of these hubs has approximately 50,000 registered populations and 8 or 9 GP practices and will have generic health and social care teams, supported by Specialist Community teams. This will be very similar to the four hubs in North and South and can be generally illustrated below:

Adults & Specialist Community Model Draft



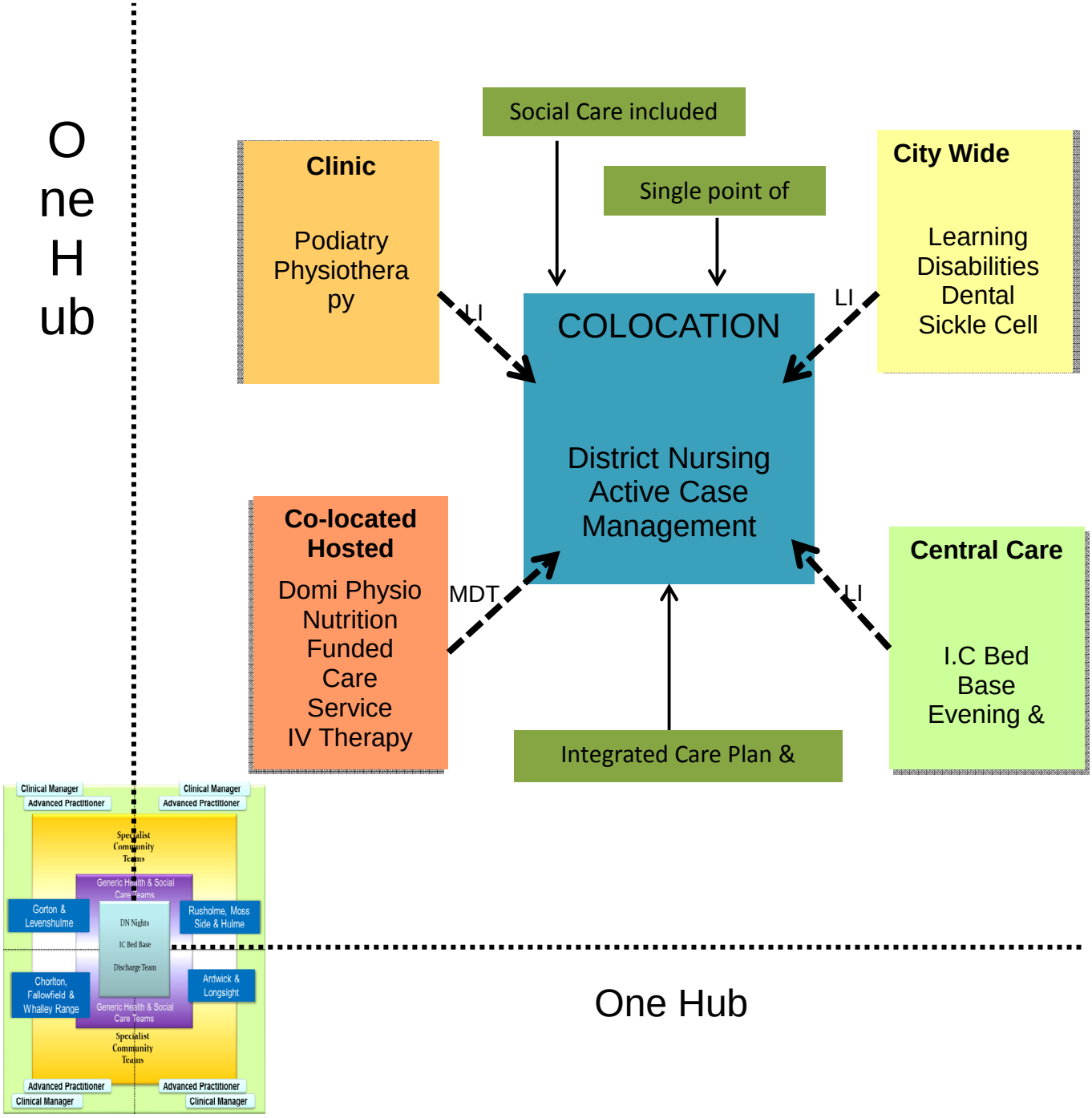
Specialist Community Teams

- District Nurses
- ACM
- IC Home pathway MDT
- Continence
- Macmillan
- Nutrition
- Funded Nursing Care

Generic Health & Social Care Teams

2.5.3 The models of care are being designed and co produced to be outwards facing into the localities, building on the existing community assets, and having an integrated health and social care workforce with primary care, with the teams being co located.

2.5.4 These models of delivery are also being designed to be integrated as a 3 locality model with the other acute providers where possible so that the city has a 12/3/1 approach to the design of services.



2.5.5 The areas that could be included in a model in the 12 hubs across the city are:

- new models of care for diabetes, heart failure and respiratory patients
- new models of delivery for phlebotomy services; home based trial without catheter and stable prostate checks

- Integrated Medicines Optimisations Service
- new model of delivery for MSK physiotherapy outpatients
- community generic teams
- scaling up and mainstreaming of new models of care

3. MHSCT

3.1 **The MHSCT** fully supports the ambition in the city to widen the scope of health and social care integration, including greater integration of mental health services with physical healthcare along the lines of the model described above.

3.2 The Trust supports the direction of travel towards the co location of multi disciplinary teams and more integrated management and processes at the neighbourhood level, the greater integration of physical and mental health care and the need to ensure services are safe, responsive and sustainable.

3.3 In order to engage fully with the vision it is recognised that the Trust's health and wellbeing and community mental health services need to be included in phase 1 of the integration process during 2015/16. These include the Community Mental Health Teams for working age and later life adults, and Primary Care Mental Health Services. There will be a further consideration of other community based services during this same time period and this may extend the scope of integration either in 15/16 or the following year. This might include Psychological Therapies and Emergency Department Liaison.

3.4 The Trust will consider and implement internal changes to its structures and management arrangements that will enable this fuller integration. The practicalities of the fit with the 12/3/1 model will need to be considered as the critical mass of services may mean that some need to operate on a '6' basis, combining 2 of the hubs in each locality rather than 12. This will be undertaken in discussion with provider colleagues and in the best interests of the city.

3.5 The Trust is open to new models of service provision and will apply the test of best interest to the community and the needs of service users. The same test will be applied to line management arrangements in the context of the multi-disciplinary neighbourhood teams and will contribute to the development of such from its experience as a Health and Social Care Trust with a Section 75 agreement with Manchester City Council.

3.6 The Trust is keen to be part of the work to develop a strategic and coordinated approach with partners to make the best use of the health and social care

estate in the city, although it should be noted that the Trust has a small number of owned assets.

4. Manchester City Council

4.1 Outlined below is the description of how MCC will be involved in the integration of services in response to the Living Longer, Living Better, One Team, Place Based Care for the services. The integration of adult social care with community health services is described later in the document.

4.2 However MCC also wants to reform the way it commissions residential and nursing care and home care services in citizens' homes as 1175 adults received nursing and residential care which amounted to 428,875 bed nights.

- 64.9% of adults in residential or nursing care are aged 65+
- 73.5% of adults in residential care and 26.5% in nursing care are aged 65+,
- 27.3% of adults in residential care and 7.77% in nursing care are aged 85+

4.3 Research and analysis of the data indicates that Manchester is an outlier on volumes and total spend on residential and nursing care and the providers are not part of the emerging wider care models for Living Longer Living better.

4.4 Currently the residential and nursing providers are not part of the wider care models for Living Longer Living Better. There is a need to reprocure provision on a values basis to ensure these providers are embedded in the new delivery model and to review the current distribution of residential and nursing homes in terms of volume and place across the health and social care landscape.

4.5 We need to ensure that there is a balance of provision which will include the development of significant additional units of extra care, better use of home care and assistive technology which will negate the need for longer term use of residential care in many instances. However, there will still be a level of need for good quality dementia care and other specialist residential provision.

4.6 We will strive to deliver joint commissioning approaches between health and social care which will improve standards of existing nursing care provision which rewards good quality outcome orientated provision. This is a more cost efficient approach which will also encourage investment in the estate and the workforce by providers and a culture of innovation.

4.7 The council also want to encourage development of new specialist nursing care provision in locations of need by the independent sector. This will involve active engagement with the sector, removal of perceived planning barriers and making best use of available land/estate within the health and social care sector to encourage development.

4.8 MCC wants to also focus on a different kind of homecare provision, building upon reablement principles and individual outcomes with a potential payment by results element for evidence of attainment. Future provision will need to overlap with core and cluster models for extra care and locality based

intermediate care solutions. This will provide a holistic service and a clear pathway for patients/citizens. Homecare staff must also be able to respond to package requests of all types and therefore there will be a need for providers to employ more highly trained and skilled staff to deliver some community based nursing tasks in addition to the traditional role of personal care. They will become embedded in the new delivery models for integrated community health and social care.

4.9 Commissioners will develop the homecare frameworks and manage efficiency by devolving an annual budget based on evidence of flow rates into home care and residential/nursing home provision. The providers will be expected to deliver the required number of individual care packages within the financial envelope. A joint health and social care panel process will operate to determine the suitability of nursing and residential placements ensuring. Community based options have been explored first.

4.10 In relation to 7 day working as part of the Greater Manchester Directors of Adult Social Services Group (DASS) Manchester strongly endorses the work to drive towards 7 day access to primary care as an inherent part of the transformation of the Health and Social Care system in GM. We believe that while there is a strong focus on GP services, partners need to work together to improve the way in which all services in the community support primary care deliver joined up services over the 7 day period.

4.11 This will mean working with partners to understand and address the wider determinants of demand for GP services and wider primary care services. This needs to include work to support people to be connected to their communities, to support adults of working age to have access to quality work, to improve standards of housing, and to remove fear of harm. We look forward to working with GPs to improve the opportunity for residents to be in control of their lives and their care.

5. North West Ambulance Service

5.1 Outlined below is the description of how NWAS will be involved in the integration of services in response to the Commissioners' 2020 Design Specification.

5.2 Devolution for Greater Manchester provides the North West Ambulance Service an opportunity to deliver more locally specific services for patients with emergency and urgent care need. There are obvious challenges for a regionally commissioned service to offer a more locally refined product, but this is something we have been working with clinicians from primary care across the North West to deliver, especially within Greater Manchester. The radical change in structure that devolution will deliver creates the need for a more bespoke and locally diverse urgent care offer which we are keen to engage with, especially being a part of developing integrated services.

5.3 We have adopted a strong leadership role within many areas of urgent care, and mindful of our impact on Emergency Department attendance together with

the disproportionate attendance to admission ratios, we feel we are ideally placed to build upon this leadership potential, especially for those pre-hospital patients with long term conditions and the frail elderly. The success or failure of large scale change programmes is predicated on our ability to stream patients into suitable alternative places of care. We further commit to address demand in Urgent Care at a Manchester level by:

- Working closely with the 'Single Point of Access' development as noted below
- Deflecting into primary and community care for frail and elderly patients.
- Using community care plans for increased admission avoidance, working with Practice Integrated Care teams
- Strengthening relationships with GP out-of-hours services.
- Supporting nursing and care homes to avoid emergency admissions.
- Working closely with GPs to reduce emergency demand.
- Reducing ambulance conveyance rates.

5.4 Manchester Aligned Response to 'Transforming urgent and emergency care services in England' states 'Ambulance services play a central role in the provision of urgent and emergency care – approximately 90% and 10% of their workload respectively' . The 'urgent care' response to both 999 and 111 calls needs to be more locally specific across the region, and we are keen to further develop this within Manchester. We are able to re-align our delivery model with the 12/3/1 place based care.

5..5 NWAS are already working with very local based initiatives within Manchester, such as community paramedics linked into primary care but also working in secondary care, with particular focus on the frail and elderly patients. At a city based level we have worked with GP out of hours providers to enable safe and timely referral into primary care for patients who would otherwise have been transported to hospital. Other initiatives such as the frequent caller programme, community care planning co-ordination, local 'safe haven' schemes, the Sanctuary project and other collaborative schemes will all align under the Manchester 12/3/1 delivery model.

Appendix 2. The Immediate Picture: How will it Look in 2016 ?

This appendix provides a description of how the proposed redesigns of Urgent Care First Response (UCFR); the integration of adult social care with community health services; changes to community mental health teams; and changes to the use of estates could take place by 2016 in a place based, one team model. These are not finalised programmes of work but examples to illustrate the type of work that is being undertaken in the city with members of the MPG and other providers of services.

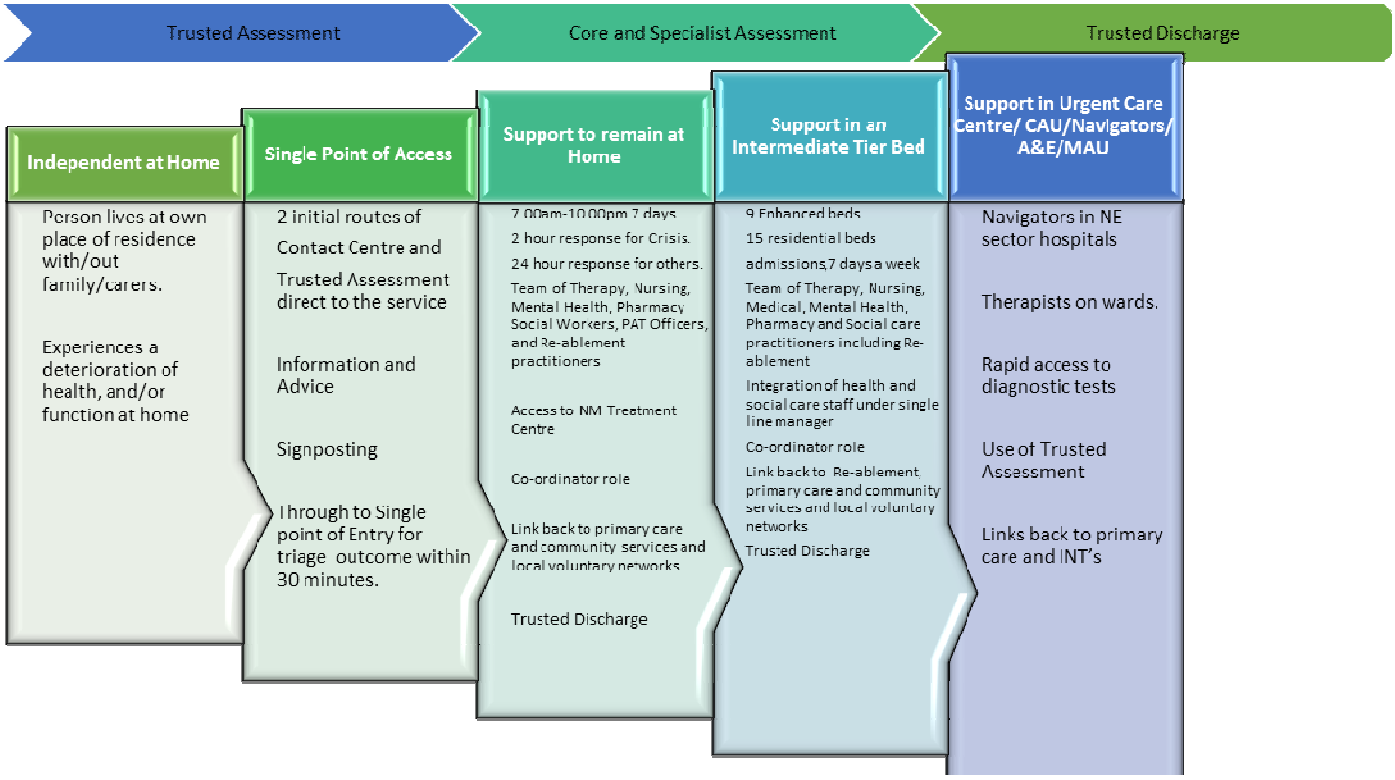
The designs below must be seen in the context of co-location and joint working of staff across these organisations

1. Integrating Adult Social Care and Community Health Services in the City

1.1 Intermediate Care and Reablement Services (ICRS)

1.1.1 Our vision in Manchester is to have a fully integrated health and social care model of intermediate care and reablement. The service offer will utilise step up and step down approaches to enable people to be more independent, empowered and confident enough to remain well at home. Our integrated model will reduce duplication, improve safety and quality, and provide a more co-ordinated and effective service for people and their families/carers. We will have a workforce which is flexible and skilled to deliver co ordinated care in the community to enable people to live longer and live better.

1.1.2 All three localities in Manchester will implement the design by April 2016. However North Manchester as an early implementer has developed an integrated delivery model with a working title of Community Assessment and Support Service (CASS) and will implement early in September 2015. The key elements of the model are represented pictorially below.



1.1.3 We will have a consistent offer across the city with the following key core components:

- Screening at a Simple Integrated Point of Access
- An integrated triage
- Trusted Assessment
- An integrated core assessment, which can then be built upon and enhanced for specialist services
- Integrated and holistic planning for independence
- Trusted discharge

1.2 Care Management Neighbourhood Teams

1.2.1 The vision for integrated community health services and social care is to develop place based care delivery models with 12 integrated health and social care neighbourhood teams from the three Acute and Community Trusts and Manchester City Council.

1.2.2 This will create a more citizen centred approach across both health and social care enabling the more effective co-ordination of services through a single integrated approach to assessment, triage, case management and care as close to home as possible.

1.2.3 The services in scope for this integrated model of delivery include the council's assessment function which includes the end to end delivery focusing on the existing new citizen journey and includes: first contact, Primary Assessment Team, Social Work, Care Management and Support Planning both within the community and within hospital settings. In health, the range of services includes community based nursing and therapy services, as outlined in the diagrams in section 6.6.7 and 6.6.8 there are a wide range of general and specialised community teams that would be part of a place based model of care.

1.2.4 An integrated health and social care service will need to be Care Act compliant which introduces a new general duty for local authorities to "promote individual well-being "The duty applies to all actions taken under the Act with respect to individual care and support.

1.2.5 In 2016 our shared intentions and ambitions are:

- Co-location of PAT (primary assessment team) and social workers who undertake work with people with complex needs and longer term work into the neighbourhood teams, to support more people to be supported at home
- Co located health and social care staff working from 12 hubs across the City
- The development of an integrated triage and allocation process to support a community based approach to provide health and social care at home and avoid unnecessary admissions to hospital
- Development of both integrated locality and workforce plans to support the health and integration model
- The design and development of a Manchester hospital social work approach

- Mainstream the multi disciplinary approaches tested across the city (North Manchester integrated care, Central Primary Integrated Care Team and South Enhanced Neighbourhood Team)
- Contribute to the design and delivery interface with urgent care first response services
- Build integrated services around local populations, linking with local third sector organisations and maximising community based assets.

1.3 Single Point of Access

1.3.1 The development of a single point of access (SPA) will be intrinsic to the success of providing integrated health and social care services, particularly as a central point for the provision of urgent care first response. The purpose of a SPA is to provide one point of entry which will provide a gateway to the range of health and care services.

1.3.2 The future success of services that are provided by integrated teams will be reliant upon the initial appropriate clinical assessment of the person's needs and signposting them to the most appropriate service. This process is known as triage, which was originally developed for war situations in order to determine the seriousness of a person's problem and how quickly they needed to be treated.

1.3.3 Across the city in the three localities there are in place varying forms of a point of access to access specific services/groups of services. Some have been in place for a while, some, such as in the north locality, have been developed as a tactical short term solution, pending the development of a citywide SPA.

1.3.4 There is much progress already in the three localities with varying solutions in place or in design across the city at present. However it is agreed that as part of the integration of adult social care with community health services the development of a citywide SPA will be in place to support integrated services by April 2016.

1.3.5 The creation of a citywide SPA will be undertaken by the citywide practitioner design team. The key aspects and areas to be covered will include:

- Scope and functionality
- Telephony systems and IMT
- Estates

1.3.6 Within the scope will be the creation of an understanding of who will access the SPA – people requiring services, health and care professionals and carers, and whether the function of the SPA will be to provide signposting to services or also to provide clinical advice. There may also be a requirement to book appointments and create appointment reminders and to provide a response to follow up calls in addition to dealing with new calls.

1.3.7 The provision of appropriate estates for the SPA will be crucial. The SPA service will be part of the '1' provision in the 12/3/1 citywide estates model of delivery. This means that it could be provided anywhere in the city as it is

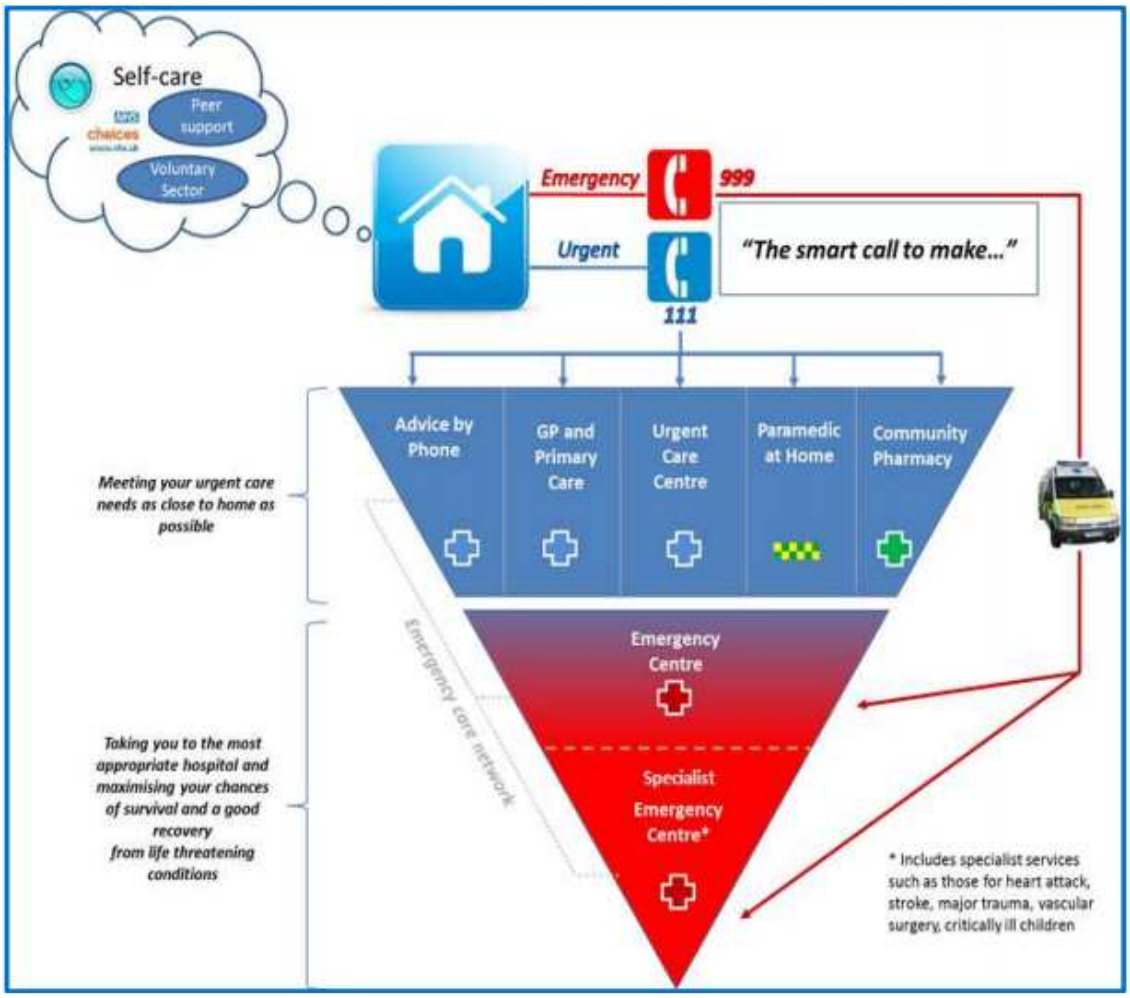
essential to ensure the building is the most appropriate to be able to provide telephony and IMT systems that are essential to service delivery. In Manchester there are a number of existing call/contact centres which include the MCC contact centre, the GP out of hour's service and the NWAS Ambulance Control Centre.

1.3.8 The challenge learned from initiating other large call handling services, for example, NHS Direct and 111, is that of the organisational development required when clinical staff work in a call centre environment. It is anticipated that a citywide SPA will be dealing with a significant number of calls per day, over a 24/7 period. In order to ensure the service is efficient and effective a system will be required that monitors the length of each call, the number of calls and how long a person waits to have their call answered. For many clinical and professional staff this is an alien environment to work in and can be challenging. We will therefore look at best practice providers and work with staff, to see how best this can work.

2. Vision for Urgent Care First Response (UCFR)

2.1 Outlined below is an illustrative description of how Urgent Care First Response across the 11 providers in the MPG could respond to the commissioners UCFR specification. This reflects the Commissioners' 2020 Design Specification, as the system should be delivered in a 12/3/1 model. The design below has yet to be agreed with the commissioners, but commissioner intention is that a redesigned UCFR will start to be implemented by 2016.

2.2 In line with Healthier Together and the LLLB programme, a Manchester vision for UCFR has started to develop which would provide support and access to appropriate services for people who feel they have an urgent care need for advice or treatment. The aim of this would be to provide 24/7 consistent standards of care and a consistent offer across the city. Within the vision, examples of this are citied as simple telephone access with access to patient records.

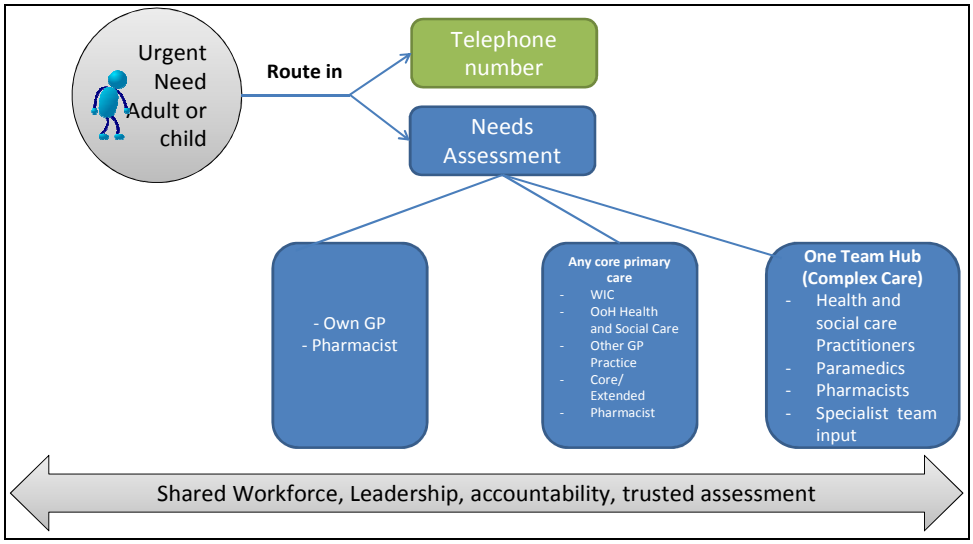


2.3 Our vision in Manchester is to reflect the proposed national model as published in November 2013 and bring together the different components of urgent care into a single unified system. This will mean that people and families with a need (or perceived need) for urgent care will be directed to the most appropriate part of the urgent care system in a timely way from whichever point of contact they use. We will have a consistent offer to all patients with reduced gaps and overlaps in service. By 2020 we will have a whole system approach to UCFR operating with three core components:

- First Contact Urgent Care
- Complex Care
- Urgent Care Day Hospital / Ambulatory Care Unit

2.4 A summary of what the three components could look like are outlined below. It must be noted that this is a first design, and it is not an agreed approach as yet across the city and with the commissioners, but work in progress.

(A) First Contact Urgent Care



(B) Complex Care

(C) Urgent Care Day Hospital / Ambulatory Care Unit

3. How Might it look different in Mental Health Services

3.1 One of the main differences with the MPG is the combining of providers across physical and mental health to deliver integrated services for the person. By working differently to deliver the Commissioners' 2020 Design Specification we think we have real opportunity to change services.

3.2 The following is an illustration of future possibilities and potential system benefits arising from place based integration of health and social care, from a mental health perspective.

3.3 Currently a number of core community based mental health teams will be integrated into the 3 locality model and establish strong interface working with the 12 hubs. They will be:

- Community Area Mental Health Teams (CAMHTs) for working age adults;
- CMHTs for later life adults, and;
- Primary Care Mental Health.

3.4 The multi disciplinary community based mental health teams for working age and later life include just over 200 staff from a variety of health and social care backgrounds. The services assess and, where appropriate, meet the social and mental health needs of people in the community.

3.5 The services are already organised to fit the 3 localities and work closely with an identified group of GP practices, with two teams in the north, central and south areas. Teams offer screening, assessment, intervention and treatments. They take the lead in co ordinating care and support and offer a range of therapeutic interventions and enable to self manage and participate in social activity. The teams also identify and provide assessments for carers.

3.6 The Primary Care Mental Health Teams include over 50 staff and support individuals suffering from common mental health problems. The teams provide assessment and triage as well as a range of brief interventions including guided self help, Cognitive Behavioural Therapy and a counselling, bereavement and mindfulness group. The service is organised into the 3 localities and links in with a range of community projects providing support to individuals.

3.7 For the future we will build on a sound base. There is already a good fit between the 12/3/1 model and the way community based mental health services are currently organised in the city. The services also already have well established and constructive relationships with primary care, acute care and other providers and services in the localities. However, the Trust recognises the considerable benefits that can be realised from further integration of community services.

3.8 We anticipate community based mental health professionals will be co located within the 3 localities working in multi disciplinary teams in the place based hubs alongside other professionals in a shared line management

arrangement. Increasingly services will be delivered in GP Practices and other venues close to home. We envisage that there will be a joined up approach to care coordination and a single care planning process, and the Trust will work with partners to establish an information management and data sharing system to enable this to happen.

3.9 Within the CAMHTs (for working age adults) we are piloting new health and social care clinics in Harpurhey. These are neighbourhood based and we are exploring the development of a primary care liaison function, stepping people down to local level care and shared care models. We are collaborating with Manchester Mind on a small, time limited project to trial a co produced, person centred care planning process for service users stepping down to lower levels of support, including the role of peers in this process. The Trust will bring this learning from this work into the One Team approach.

3.10 Some teams are relatively small and in these instances individual members of staff will cover more than one community hub. So, for example, we for Later Life services we envisage organising memory assessment, dementia support and liaison at the 3 locality level. Later Life CMHTs will provide more support to GPs through liaison, education and post diagnostic support, and we anticipate moving the hospital based out patient clinics into community venues. We have already started work to review existing arrangements for how GP practices link to the service to ensure close alignment to the 4 hubs in each locality.

3.11 The trust is currently working with commissioners on a revised model of psychiatric liaison to support a holistic approach to the mental and physical wellbeing of patients in hospital. We anticipate greater collaboration between mental health services and the Acute Trusts to integrate service provision within the acute hospital setting. Benefits should include:

- Earlier identification of mental health problems
- Improved access to mental health services
- Reduced ED waiting times, re-admissions and lengths of stay
- Reduced new admissions into 24 hour care
- Improved the knowledge and skills of acute hospital clinicians
- Improved health outcomes
- Improving discharge planning, post-discharge support and rehabilitation

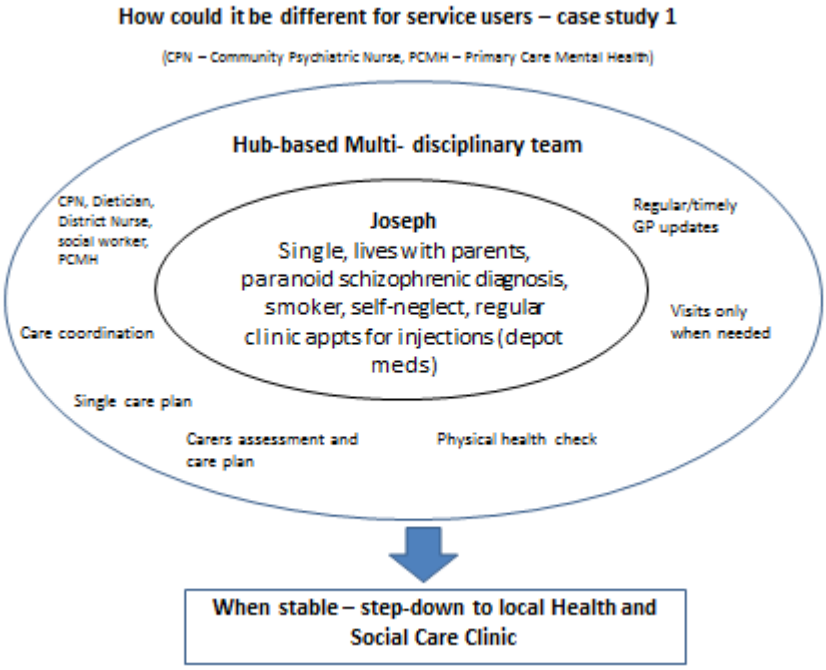
3.12 The Trust can see the benefit of closer liaison with housing and the voluntary sector. So, for example, we are already a partner with the Shelter led Inspiring Change Manchester looking at system reform to better support some of the most vulnerable groups in the city. We will continue to roll-out the highly regarded ‘Connect 5’ mental health awareness training programme to support prevention and early intervention. In a very different context, we propose to work with acute colleagues to give staff the competence, confidence and support to incorporate mental health into rapid triage and assessment in the emergency department.

3.13 The Trust will continue to promote greater independence by supporting self care and self management. We are planning, for example, to review and

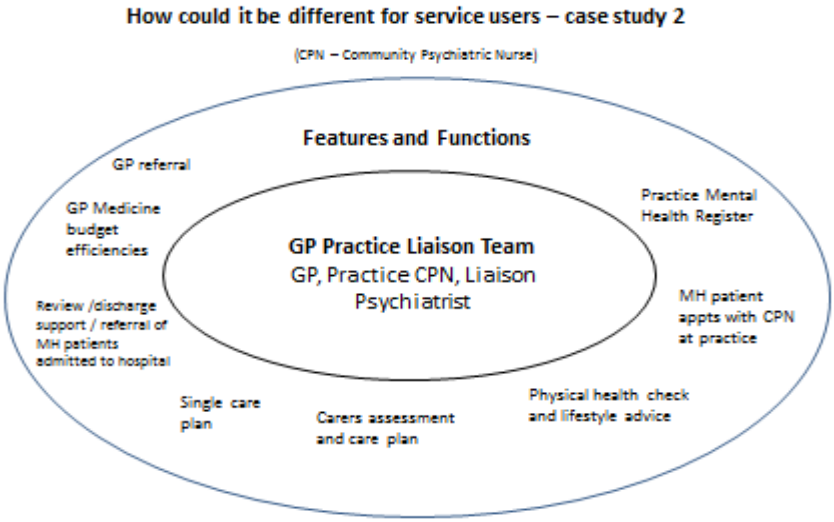
improve the quality of crisis care plans to help prevent escalation and reduce the demand on urgent care services. One benefit of the provider partnership will be to share expertise in the use of digital solution that can support self-care and self-management.

3.14 One of the main differences with the MPG is the combining of providers across physical and mental health to deliver integrated services for the person. By working differently to deliver the Commissioners' 2020 Design Specification we think we have real opportunity to change services.

3.15 How will it be different for service users – case study 1:



3.16 How will it be different for service users – case study 2:



4. How our Estate could be different in 2016

4.1 A tangible example of what we need to agree to make the designs a reality is how we need to physically enable the movement of services into the 12/3/1 model in the city. This can be seen through the city wide work stream for estates.

4.2 A citywide estates strategy, in response to the Commissioners' 2020 Design Specification, has been developed. The response comprises an immediate solution in order to provide appropriate estates on a 12/3/1 basis for April 2016 in addition to a longer term response in preparation for 2020.

4.3 The immediate solution will enable staff to be co-located at the point of integration in April 2016. It is envisaged that 12 hub bases will be identified; each of which will be supported by locality spokes. As a minimum standard, each hub will provide the neighbourhood place based services. Dependent upon geography and the physical state of the building, some hubs will also provide locality services, and some may provide citywide, locality and place based services.

4.4 The spokes will be different in each locality, dependent upon population need as demonstrated in the place based hubs diagram. For April 2016, the bases will accommodate the staff providing the services and not the local service access for people/service users. In order to ensure this tactical provision, MCC and locality estates teams, in collaboration with IT and operational teams are in the process of appraising current premises that span health, social care and primary care to establish the 12 basis. This solution is reliant upon sufficient appropriate space being available within the current building stock and therefore there are associated risks.

4.5 From a strategic point of view, the estates enabling work stream is also working with localities in the following areas:-

4.6 Gorton

4.6.1 Gorton has been identified by a number of partners as a priority for investment for some time due to inequality in the demand for services and provision.

4.6.2 The intention is to develop Gorton as a scalable pilot to inform a larger programme of estates transformation throughout Manchester.

4.6.3 A dedicated Gorton Group has been established to address this inequality; they recently ran a workshop that identified the following potential outputs:

- Construct a new Health and Social Care Hub in the centre of Gorton.
- Move selected health services from hospital into a community facility within the heart of Gorton.
- Provide sufficient capacity to accommodate the planned housing growth.

- Deliver a broad range of GP and Community health services from the new facility.
- Include complementary public services including housing office, employment advice, pharmacy and other services such as Citizens Advice Bureau.
- Develop extra care facilities within the area as part of the wider housing redevelopment and regeneration programme.
- Use the school buildings more as community assets to accommodate local sports clubs and community groups.
- Rationalise the poor quality public buildings and make better use of the good ones.

4.6.4 Additional resource is required to further develop proposals for a new hub in Gorton; funding opportunities are currently being explored.

4.7 North Early Implementer

4.7.1 The enabling work stream is working specifically in the north locality in order to support the early implementation of health and adult social care integration. Initially this work comprises providing an appropriate physical base for the new Community Assessment and Support Service by September 2015.

4.7.2 Collaborative work is ongoing with IT teams in order to ensure that all estates provision is adequately equipped to support the IM&T requirements of the integrated teams.

4.7.3 The purpose of establishing an early implementer site was to ensure that lessons learnt were cascaded throughout the citywide work, and a number of learning points have so far been identified for future estates development across the city.

4.8 North Manchester Hospital Site

4.8.1 In line with Healthier Together health and social care transformation and the Trusts' transformation programme North Manchester General Hospital site is undergoing re-development. This will see the site re-developed to offer a much broader provision of health and well being services which will go beyond traditional and statutory health services. This will require investment. The work is being led by a North Manchester Strategic Estates group which comprises memberships from a range of stakeholders. The work is closely linked to the Living Longer, Living Better programme and One Team Place based Care delivery.

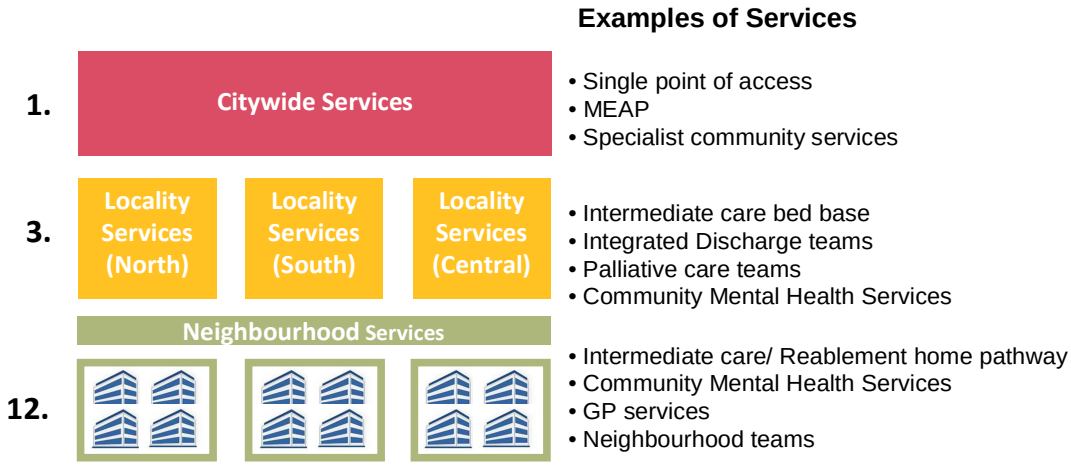
4.9 Withington Community Hospital

4.9.1 By 2020, we would expect the excellent services on Withington campus to be characterised by:

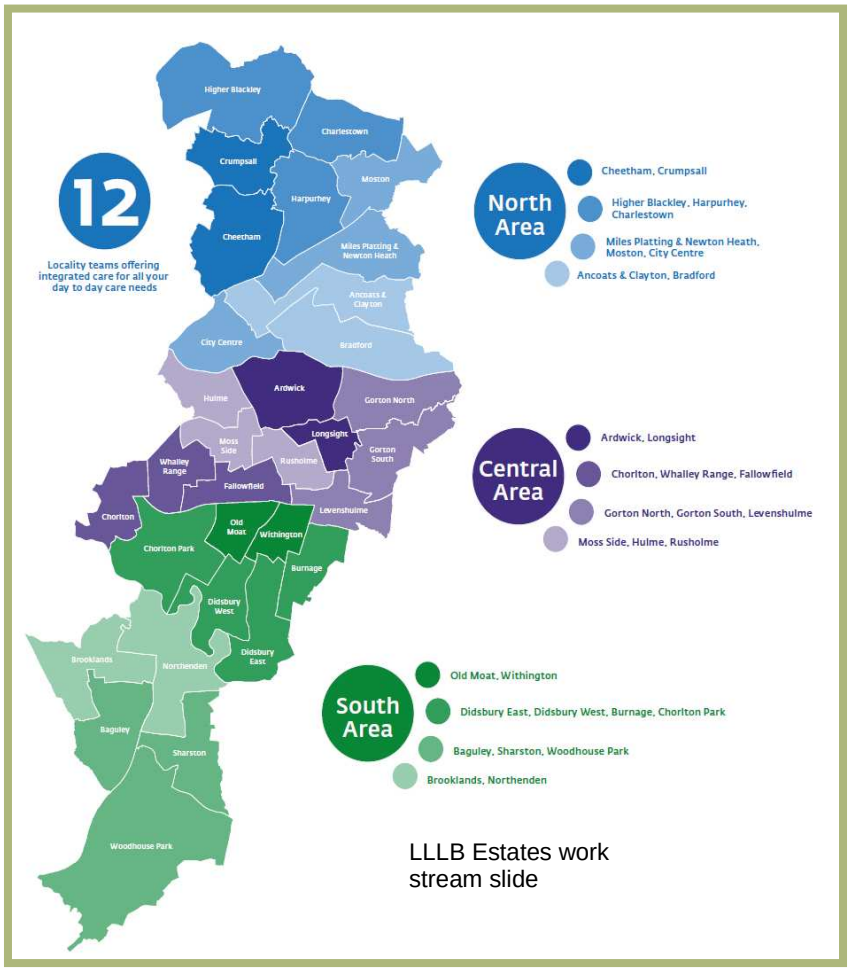
- More integrated services, within which organisational boundaries are broken down on the Withington site and the patient becomes the focal point
- There are clear and well understood pathways for patients with an emphasis on planned care, community care and long term condition (LTC) management
- Increased incidence of one stop shops, rapid access to multi-disciplinary teams and diagnostics and enhanced access / opening hours
- An integrated care campus facility providing a host of local high quality services for local people

Example: Health & Social Care: 12 / 3 / 1 Estates Delivery

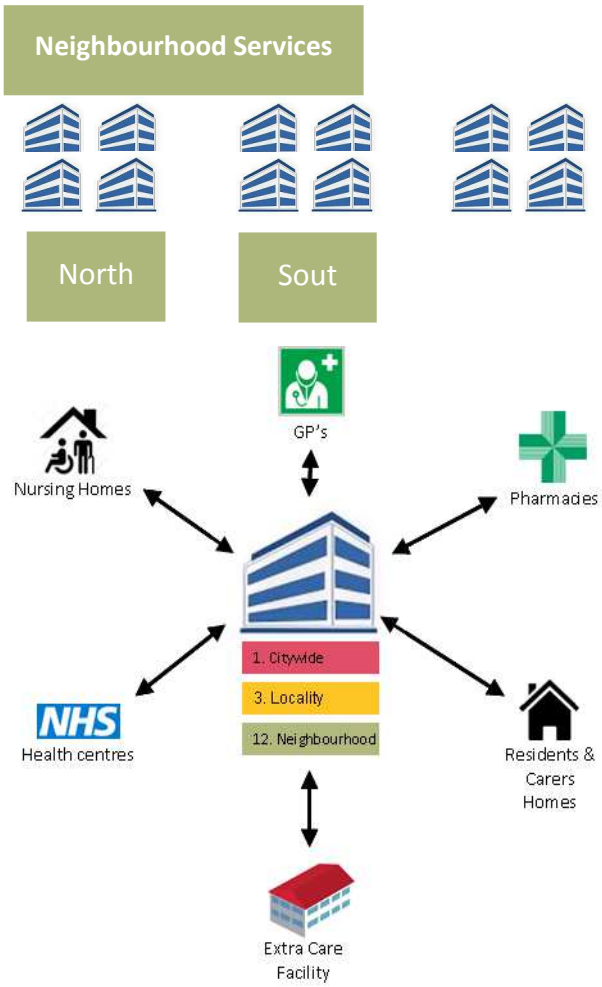
Estates 12/3/1 model



Nb. The services above are indicative and only provided to help illustrate the 12 / 3 / 1 model for Phase 1 integration. This breakdown of services shouldn't be interpreted as the future delivery model



LLLB Estates work stream slide



Illustrative Example – Place Based Hubs in Central